ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
1740 W. ADAMS ST., SUITE 4600, PHOENIX, ARIZONA 85007
PHONE (602) 364-1PET (1738) FAX (602) 364-1039
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received 2/24/20

COMPLAINT INVESTIGATION FORM

If there is an issue with more than one veterinarian please file a separate Complaint Investigation Form for each veterinarian

PLEASE PRINT OR TYPE

FOR OFFICE USE ONLY

Date Received: Feb. 24, 2020 Case Number: 20-79

A. THIS COMPLAINT IS FILED AGAINST THE FOLLOWING:

Name of Veterinarian/CVT: Megan Helgeson BVMS

Premise Name: VetMED

Premise Address: 20610 N. Cave Creek Road

City: Phoenix State: AZ Zip Code: 85024

Telephone: (602) 697-4694

B. INFORMATION REGARDING THE INDIVIDUAL FILING COMPLAINT*:

Name: Lisa and Gary Kravetz

Address: [redacted]

City: [redacted] State: [redacted] Zip Code: [redacted]

Home Telephone: _____ Cell Telephone: [redacted]

Mr. and Mrs. Kravetz respectfully request that communications be directed to their attorney, Tricia Schafer, Vitality Law PLLC, 6929 N. Hayden #C4-199, Scottsdale, AZ 85250, 602.469.6402, tricia@vitalitylaw.com

**STATE LAW REQUIRES WE HAVE TO DISCLOSE YOUR NAME UNLESS WE CAN SHOW THAT DISCLOSURE WILL RESULT IN SUBSTANTIAL HARM TO YOU, SOMEONE ELSE OR THE PUBLIC PER A.R.S. § 41-1010. IF YOU HAVE REASON TO BELIEVE THAT SUBSTANTIAL HARM WILL RESULT IN DISCLOSURE OF YOUR NAME PLEASE PROVIDE COPIES OF RESTRAINING ORDERS OR OTHER DOCUMENTATION.*

C. PATIENT INFORMATION (1):

Name: Ernie

Breed/Species: Yorkshire Terrier

Age: 5 Sex: M Color: Brown

PATIENT INFORMATION (2):

Name: _____

Breed/Species: _____

Age: _____ Sex: _____ Color: _____

D. VETERINARIANS WHO HAVE PROVIDED CARE TO THIS PET FOR THIS ISSUE:

Please provide the name, address and phone number for each veterinarian.

The "issue" is that VetMED's non-certified veterinary assistant under the direct supervision of Megan Helgeson BVMS misplaced Ernie's nasogastric feeding tube through his trachea, causing his death on January 22, 2020. VetMED radiologist Clifton Crooks DVM, MS, DACVR did not treat Ernie but authored the radiology report describing the fatal error. Michelle Erney VMD performed compressions on Ernie at VetMED. Address/phone in Section A above.

E. WITNESS INFORMATION:

Please provide the name, address and phone number of each witness that has direct knowledge regarding this case.

Stacy Duffy, DVM, at Raintree Medical Center was Ernie's regular veterinarian. [redacted]. Dr. Duffy had nothing to do with Ernie's death, but has studied Dr. Crooks' report and can comment on it. In addition to Lisa ([redacted]) and Gary ([redacted]) Kravetz, our daughter Brookelynn Kravetz ([redacted], same address) was present at VetMED when Ernie died.

Attestation of Person Requesting Investigation

By signing this form, I declare that the information contained herein is true and accurate to the best of my knowledge. Further, I authorize the release of any and all medical records or information necessary to complete the investigation of this case.

Signature: Lisa Kravetz

Date: February 24th, 2020

F. ALLEGATIONS and/or CONCERNS:

Please provide all information that you feel is relevant to the complaint. This portion must be either typewritten or clearly printed in ink.

Please see attached.

Section F - Kravetz Complaint re: Megan Helgeson (Arizona license #7443)

On January 22, 2020, a VetMED veterinary assistant under the direct supervision[1] of Megan Helgeson BMVS[2] fatally wounded our beloved 5-year-old Yorkshire Terrier, Ernie.

My family's attorney sent a letter [Exhibit 1] to VetMED's Medical Director requesting information for this Board complaint. Though VetMED's counsel promptly responded that the assistant who killed Ernie is not licensed or certified, VetMED has provided none of the other information sought in Exhibit 1, nor (to my knowledge) has VetMED sent a final report to the referring veterinarian.[3]

Nevertheless, we believe we have sufficient information to inform the Board of the circumstances of Ernie's death. We have significant concerns that the assistant who killed our dog is a danger to other animals, and that Dr. Helgeson's failure to adequately supervise the assistant constitutes "unprofessional or dishonorable conduct" as described in A.R.S. § 32-2232.[4]

I know that Dr. Helgeson was overseeing Ernie's care on January 22 because it was Dr. Helgeson who called me mid-morning to suggest a nasogastric feeding tube, and approximately one hour after obtaining my consent to proceed, it was Dr. Helgeson who called to inform me of the shocking news that "Ernie had an event."

The "event" proved to be an appalling euphemism for the assistant (whose identity VetMED refuses to disclose[5]) advancing the feeding tube through Ernie's trachea and fatally puncturing Ernie's lung. As the directly supervising veterinarian, Dr. Helgeson is professionally responsible for the unprofessional and dishonorable conduct of "cruelty to

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1 "'Direct supervision' means that a licensed veterinarian is physically present at the location where animal health care is being performed." A.R.S. § 32-2201(8).

2 "Supervising veterinarian" means a licensed veterinarian who is responsible for the care rendered to an animal by a ... veterinary assistant." A.R.S. § 32-2201(21).

3 Dr. Helgeson has a duty to do so pursuant to Ariz. Admin. Code § R3-11-501(8): "A veterinarian shall provide records or copies of records of veterinary medical services ... to an animal owner or another licensed veterinarian ... within 10 days from the date of the animal owner's ... request."

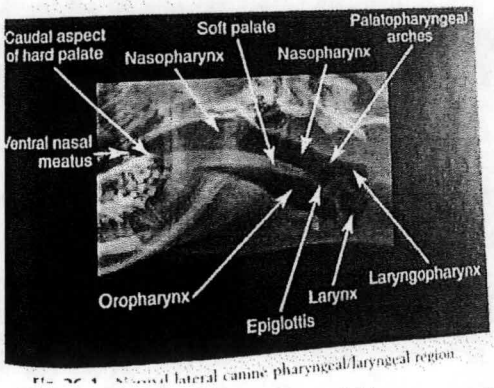
4 "Unprofessional or dishonorable conduct" includes "Malpractice, gross incompetence, or gross negligence in the practice of veterinary medicine" and "medical incompetence in the practice of veterinary medicine." A.R.S. § 32-2232(11), (22).

5 We would like the assistant's name so that we can file a police report for animal cruelty. A.R.S. § 13-2910(3), (5). After the "event," Dr. Helgeson told us that this particular assistant had experience placing feeding tubes and had done so on numerous occasions. If true, this leads me and my family to conclude that the assistant, if not incompetent, must have "intentionally, knowingly, or recklessly" misplaced Ernie's feeding tube and therefore engaged in criminal behavior. In addition, while we understand that the Board may not be in a position to influence personnel decisions and that the Board may not have jurisdiction over the assistant, my family feels strongly that the assistant should be terminated.

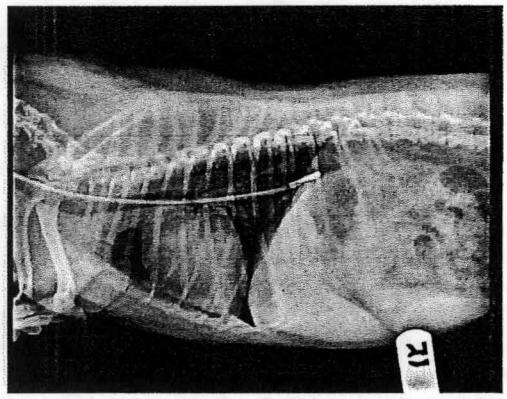
or neglect of" Ernie, which includes "negligently ... mutilating an animal, [o]r killing an animal in an inhumane manner." A.R.S. § 32-2232(23).

As I was numbly trying to process the sudden and horrific loss of our precious boy, Dr. Helgeson went on to explain that she was not in the room during Ernie's "event," but that the assistant summoned her "when Ernie's gums started turning blue." As confirmed by the radiology report [Exhibit 2], Dr. Helgeson did not ensure that an image was taken at the beginning of the insertion -- the crucial time to verify that the feeding tube is directed toward the esophagus. *See* Nelson & Couto, SMALL ANIMAL INTERNAL MEDICINE, 3rd Ed. pp. 485-495.

Instead, the assistant advanced the tube through Ernie's trachea *and then started capturing images of the fatal damage*. The radiology report confirms that "[o]n all images, an opaque nasogastric feeding tube and internal stylet are within the lumen of the trachea...." [Exhibit 2 p. 1] Dr. Helgeson explained that the assistant did not know that the tube was going into Ernie's trachea because "he didn't cough."



This anatomical image would have provided visual cues to guide the feeding tube to Ernie's esophagus. (Source: textbook in Ernie's regular veterinarian's office).



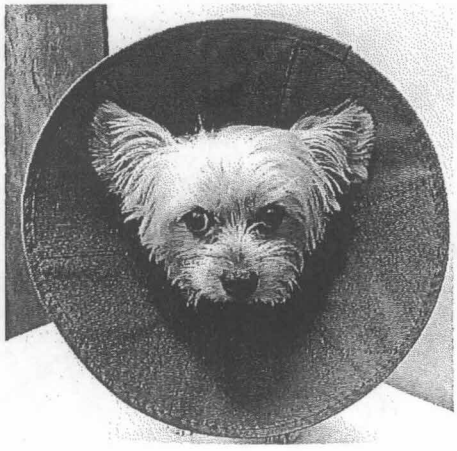
Instead, this was the first image the assistant took of Ernie's feeding tube. The tube had already proceeded through Ernie's trachea to his diaphragm.

After Ernie died, Dr. Helgeson told me that she would change her protocol going forward and always make sure she is present when a feeding tube is inserted. Given what I've since learned about the precision required to insert a feeding tube, I'm surprised a non-certified assistant would be allowed to do (or be capable of doing) it at all.

Ernie did not have a chronic or fatal diagnosis when he was admitted to VetMED on January 21, 2020. [Exhibit 3] The consensus was acute pancreatitis. Raintree Medical Center referred him for overnight fluids and an ultrasound. Ernie had a history of occasional seizures, most recently on January 15, 2020. VetMED DVM Seth Lautenschlager interpreted Ernie's ultrasound for me and did not express any concerns about undernourishment or the potential need for a feeding tube.

Ernie's appetite had been spotty for the 5-6 days preceding his death. He spent the night of January 16 at VCA McCormick Ranch, and I had taken him for subsequent

daily visits (except Sunday) to Raintree for fluids. VetMED's records show his weight as 5.3 kg (11.1 lb.) the day before he was killed.[6] The below photo, taken the day before he was killed, confirms VetMED's intake description that he was "bright, alert, [and] responsive to handling."



I called VetMED early on January 22 to check on Ernie. The employee who had watched Ernie throughout the night said he had a good night, his vitals were great and he was alert. She said I should expect a call from a doctor around 10am.

Dr. Helgeson called me at or about the predicted time, and I put the call on speaker so my adult daughter Brookelynn Kravetz could also hear. Dr. Helgeson asked us when Ernie last had a "full meal." I responded that it had been approximately 6 days since he had eaten a normal meal, though he had been picking at food periodically. Dr. Helgeson suggested a feeding tube in order to get Ernie nourished so he could come home.

- Had Dr. Helgeson informed me of the intricacies involved with a feeding tube, I would have asked more questions.
- Had Dr. Helgeson informed me of the risks of (a) the occurrence of potential misplacement and (b) the consequences of misplacement, I would have questioned the need for a feeding tube, particularly as Ernie had been professionally hydrated for nearly a week and likely would eat normally when back home and not in and out of cars and medical facilities.
- Had Dr. Helgeson informed me that she had only been a licensed veterinarian for 2½ months, I would have asked of one of her more seasoned colleagues (or Ernie's regular vet) for a second opinion regarding whether a feeding tube was necessary.
- Had Dr. Helgeson told me that her usual protocol was to allow an unlicensed assistant to perform the painstaking task of inserting a tube through a dog's tiny body, I would have insisted that an experienced veterinarian perform that task.

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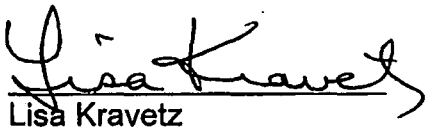
[6] On January 16, VCA recorded Ernie's weight as 12.1 lb. Assuming these two scales are perfectly calibrated, he had likely lost only one pound over the preceding week, which had been a stressful time for him and likely affected his appetite.

All Dr. Helgeson told me was that feeding tubes are considered common and routine for dogs with acute pancreatitis. I had no reason to question her opinion until it was too late.

Once Dr. Helgeson informed me that her assistant had fatally wounded Ernie, I immediately informed Brookelynn and my husband Gary Kravetz. Ernie was a deeply adored member of our family, so we left work and school and jumped into our cars and sprinted into VetMED. Gary arrived first, and Dr. Helgeson invited him into the treatment room, where Michelle Erney DVM had been performing chest compressions on Ernie. Ernie's chest had been surgically opened. Brookelynn and I arrived at VetMED shortly thereafter.

Moments later, and just a couple hours after we were told that Ernie had been doing well, Dr. Helgeson and another VetMED staff member simply said "Sorry" as they handed our heartbroken family Ernie's bandaged corpse.



Lisa Kravetz

February 24, 2020

Exhibits
1: Vitality Law letter
2: Ernie's VetMED radiology report
3: Ernie's other VetMED records

EXHIBIT A

VITALITY LAW

Vitality Law PLLC
Tricia Schafer
tricia@vitalitylaw.com
602.469.6402
www.vitality.law
6929 N. Hayden Road
Suite C4-199
Scottsdale, AZ 85250

VIA ELECTRONIC and U.S. MAIL

January 29, 2020

Stephanie G. Foote, DVM
Medical Director
VetMED Emergency & Specialty Care
20610 N. Cave Creek Road
Phoenix, AZ 85024
vetmedaz@vetmedaz.com

Re: Ernie Kravetz - January 22, 2020

Dear Dr. Foote:

I represent Lisa and Gary Kravetz.

As you are likely aware, a VetMED technician abruptly killed the Kravetz's 5-year-old Yorkshire Terrier "Ernie" at VetMED on January 22, 2020. I trust that you will understand my clients' desire for information, and that presently their shock and profound grief prevent them from requesting it themselves. Time is of the essence, however, while memories and evidence are fresh. For this reason, Mrs. Kravetz has signed the enclosed release and I am authorized to seek the information on the family's behalf.

Your receptionist Tara accepted my request that PALS deliver Ernie's remains to the Kravetz's residence rather than to VetMED. Your continued cooperation is appreciated, with particular attention to the following:

1. Please provide the name of the technician ("Technician") who misplaced the nasogastric feeding tube as described in Dr. Crooks' January 22 Radiograph Interpretation.
2. Please indicate whether the Technician is certified or licensed in any respect, and if so, by what credentialing entity.
3. Please provide the name of the veterinarian(s) who provided services to Ernie on January 22.
4. Please provide the name of the responsible veterinarian at VetMED on January 22.
5. Please preserve all electronic, photographic, digital, and physical records relating to the Technician, any of the above-referenced veterinarians, and Ernie from January 20, 2020 through the present. This includes, but is not limited to, any and all email accounts and databases to which the

Technician and veterinarians had access before and after Ernie's death. This also includes any surveillance camera footage or audio recording in the location where Ernie was killed.

6. Please provide all policies and procedures regarding VetMED veterinarian supervision of staff for procedures on patients.
7. Please specify the last time the Technician was drug-tested; any past performance issues with the Technician; and whether the Technician regularly wears corrective lenses.
8. Please provide the maintenance schedule and repair history on the device that captured the four images included with Dr. Crooks' January 22, 2020 report.
9. Please provide Ernie's final report that is now past due. Your staff represented to Mrs. Kravetz last week that this report would be forthcoming, and it is our understanding that the referring practice, Raintree Pet Resort & Medical Center, is awaiting it as well.

Kindly respond by February 10.

Cordially,

Tricia Schafer

Enclosure

Copy via postal mail:
Compassion-First Pet Hospitals
106 Apple Street
Tinton Falls, NJ 07724

Copy via electronic mail:
JAB Holding Company S.à.r.l.
info@jabholco.com

Copy via electronic mail:
Megan Helgeson, BVMS
megan.helgeson@vetmedaz.com

VITALITY LAW

Vitality Law PLLC
Tricia Schafer
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6929 N. Hayden Road
Suite C4-199
Scottsdale, AZ 85250

I hereby authorize my attorney, Tricia Schafer, to obtain any and all records regarding my family's 5 year old Yorkshire Terrier, Ernie Kravetz, who was pronounced dead at VetMED Emergency & Specialty Veterinary Hospital on January 22, 2020.

Ms. Schafer is further authorized to have conversations about Ernie's care with any veterinary medical professional.

Lisa Kravetz

Date 1/26/2020

20-79

Ernie Kravetz, a 5 year old male neutered Yorkshire Terrier, was transferred to me 1/22/20 by the overnight doctor, Dr. Seth Lautenschlager, for ongoing treatment of suspected acute on chronic pancreatitis. His clinical signs included inappetence, vomiting, and abdominal discomfort. Upon transfer I reviewed the available medical records and performed my physical examination. Ernie was hemodynamically stable and eupneic with normal lung sounds. His abdomen was tense but not overtly painful upon palpation at this time. Additional physical examination abnormalities included an overweight body condition (body condition score 7/9), mild to focally moderate dental calculus with mild generalized periodontal disease. He had a right cephalic intravenous (IV) catheter that was in place and patent. His blood pressure via doppler at 8am was 180mmHg with a heart rate of 130 beats per minute. While resting comfortably in his cage he was quiet alert and responsive but mildly anxious when handled. Following examination Ernie was started on oral gabapentin 50mg by mouth every 8 hours for analgesia. As Ernie was euvolemic and appeared euhydrated his IV fluid rate was reduced from 24ml/hr of Plasmalyte [2.4 times his resting energy requirement (RER) which parallels his daily water requirement] to 15ml/hr (1.5 times RER) to account for his daily water requirement and potential ongoing losses from nausea and or emesis. Blood work (electrolytes, packed cell volume, and total protein) was performed at 10am. His electrolytes within normal limits at this time. His packed cell volume was 39% and his total protein was 7.1g/dL with icteric serum.

A focused recheck abdominal ultrasound was performed by Dr. Crooks, DVM, DACVR which revealed that the pancreas was similar in size, margination, and echogenicity/echotexture as the previous day. There were no changes to the peripancreatic area and no doppler flow noted within a portion of the body of the pancreas concerning for a region of possible early necrosis. Additionally, a newly identified moderate sized anechoic region was noted dorsal/deep to this focal region that could represent a cyst or sterile abscess.

Ernie was continued on a constant rate infusion of fentanyl at 3mcg/kg/hr for IV analgesia, maropitant 1mg/kg IV for nausea/emesis, and pantoprazole 1mg/kg IV q12hr for gastroprotection. He was also continued on his owner's medications for anticonvulsant therapy (phenobarbital and levetiracetam). Following his abdominal ultrasound, Ernie was offered food and showed no interest. I called the primary number on record and spoke with owner, Lisa Kravetz. I updated her regarding his current condition – stable but anorectic, comfortable with his current pain medications, and no bouts of vomiting, diarrhea, or regurgitation appreciated today. I discussed his recheck focused abdominal ultrasound findings – static changes to most of the pancreas with a similar area of concern for possible early necrosis, possible pancreatic cyst or sterile abscess that will be monitored via ultrasound. Informed her that his prognosis is guarded to poor and that the treatment for pancreatitis consists of symptomatic and supportive care. I asked her when Ernie last ate and she stated that he had only consumed a few bites of food since last Thursday (1/16/20) but had vomited after eating and was not able to keep the food down. His last full meal to the best of her recollection was prior to 1/16/20. Based on the severity of his inappetence (approximately 6 days of poor appetite) and his concurrent weight loss (0.43kg or 0.95lb, equating to 8% of his body weight in the past 5 days), I recommended starting enteral nutrition via a nasogastric tube (NGT). I discussed the benefits to an NGT including a means of delivering nutrition and medications to a patient who is not eating on their own accord, as well as a means to measure and remove any fluid building up in his stomach (gastric residual volume) which can be an indicator of poor gastrointestinal motility. I informed

her that Ernie may require sedation for this procedure but that he is currently receiving a fentanyl CRI and that he may be amenable to placement without additional sedation. I informed her of the risk of possible medication reactions if a sedative is given and the most common complications associated with NGT placement including epistaxis and irritation. I also informed her of the cost of the NGT (~$300-400) and she consented to its placement. I recommended ongoing supportive care and informed her that I would put together an ongoing care estimate for an additional 24-48 hours of care and that I would contact her later today regarding the estimate and an additional update on Ernie. Additionally, I recommended reassessing Ernie's progress every 24 hours and making additional plans from there. She thanked me for the update.

I added orders to Ernie's treatment plan for 12pm to place an NGT and confirm appropriate placement with a NGT placement radiograph. Rebecca Kelley (veterinary technician) was tasked with arranging placement of his NGT. At approximately 12pm Dr. Janet Bailey, DVM, DACVIM informed me that she was asked to assess the NGT placement radiograph and was concerned that it was in the correct position. I walked with Dr. Bailey from the doctor's office to the radiology room directly across the treatment area and assessed the placement radiograph that was on the viewing screen at that time which showed the NGT within the trachea and not the esophagus, and the end of the NGT within the retroperitoneal space. Dr. Bailey had already instructed Rebecca to remove the NGT and as I walked into the radiology room Ernie's NGT was removed and he developed respiratory distress. His mucous membranes appeared cyanotic and he developed an agonal breathing pattern. I immediately took Ernie from the radiology room to the STAT triage wet table and started cardiopulmonary cerebral resuscitation (CPCR) including endotracheal tube placement and manual ventilation. After initiating CPCR I performed a brief thoracic FAST (focused assessment with sonography in trauma) and identified a pneumothorax. Thoracocentesis was immediately performed and air was continuously aspirated confirming the presence of a pneumothorax.

While CPCR and concurrent thoracocentesis was being performed I contacted Lisa at approximately 12;20pm and informed her that Ernie arrested during NGT placement and that we are currently performing CPR on him but have yet to get him back (achieve return on spontaneous circulation). I informed her that my primary concern for the cause of his arrest event is an air leakage from his lungs (pneumothorax) due to trauma for the NGT leading him to stop breathing. I recommended open chest CPCR if she would like to continue our resuscitation efforts for Ernie which she approved. She stated that she would head to VetMED immediately. I then performed open chest CPCR on Ernie. Return of spontaneous circulation was not appreciated. His owner, Gary Kravetz, arrived at VetMED first and requested to see Ernie. I relayed the same information I gave his wife, Lisa, over the phone and that Ernie has not responded to CPCR efforts thus far. I warned him that we were currently performing open chest CPR and that Ernie was covered largely in drapes aside from the portion of the body with his chest exposed. He stated that he would like to see him regardless and I brought Gary to the treatment area where a team of veterinary technicians and doctors had continued CPCR on Ernie while I was speaking with Gary. After Gary saw Ernie I escorted him to an exam room where I asked if he wanted me to continue CPCR efforts. He stated that his wife should be arriving shortly and that we should continue until then. Lisa Kravetz and her daughter arrived shortly thereafter. I updated all three of them at that time and stated that we were unable to get Ernie back thus far but were continuing CPCR. Lisa asked what happened and I informed her that I suspected that the NGT

was accidentally placed into the windpipe (trachea) and not the esophagus accidentally, which lead to an arrest event due to puncture of his lung and a subsequent pneumothorax which caused him to stop breathing. His respiratory pattern acutely changed following removal of the NGT and his gums became blue (cyanotic). I stated that the radiograph I assessed showed inappropriate placement of the tube and I suspect this was the cause of his arrest, but that there were additional radiographs I needed to review. I stated that I had not yet had a chance to review the prior radiographs Rebecca had taken as my primary concern was Ernie's CPCR.

I excused myself from the room to check on Ernie – CPCR was being continued and ROSC was not achieved. After returning to the room with Ernie's owners they elected to stop CPCR efforts. I informed them that the likelihood of getting him back at this time was minimal. CPCR was discontinued at 1:02pm. Following discontinuation of CPCR a padded bandage was placed over Ernie's thoracic incision site and he was brought to his owners for visitation which they had requested. I reviewed all radiographs taken (four right lateral NGT placement radiograph) which showed the NGT within the trachea and not the esophagus. In all images the NGT is visible within the trachea and the caudal portion of the NGT extends past the diaphragm. The fourth image in the series also showed possible gas foci superimposed over the heart. A request for radiologist review was submitted at that time to Dr. Clifton Crooks, DVM, DACVR. I spoke with Rebecca Kelley at that time about the NGT placement and she informed me that he tolerated the tube placement, breathed normally throughout, and at no time started coughing or became distressed until after the tube was removed.

Ernie's owners visited with his body. While his owners visited they asked for further clarification on his arrest. I informed them that my primary differential was respiratory arrest due to an iatrogenic pneumothorax from trauma associated with the NGT. I offered my sincerest condolences for their loss and stated that this is a very rare complication of NGT placement. I informed them how very sorry I am that Ernie suffered a fatal complication to a rather routine procedure and that I can't imagine what they are going through. I informed them that NGTs are placed numerous times per week at VetMED, as well as the other hospitals I have worked at in the past, and that this complication is not a common occurrence or one I have experienced in the past despite hundreds of NGT placements. I offered submission of Ernie's body to an outside laboratory for necropsy to confirm the suspected cause of his arrest. They declined necropsy and elected private cremation with ashes returned. I again offered my condolences for Ernie and informed all three of his owners that we (VetMED) would be altering the way we place NGTs in the future given what has happened to Ernie. Lisa stated that she is very sad that Ernie died as a complication of this procedure but that it gave her comfort that we would be changing the way we place NGTs in that Ernie's death would help prevent this complication from occurring in the future. Lisa's daughter stated that she was in nursing school and that she was very distraught. She asked about emotional support and I stated that we did not have anyone at VetMED, such as a social worker, but that I would have our receptionists bring them information regarding a helpline and contact information for PALS grief support. She thanked me for looking into grief support for her. I spoke with the receptionists at that time who provided her with a brochure with PALS grief support contact information. Following their visitation with Ernie, all three of his owners departed VetMED.

DOUGLAS A. DUCEY
- GOVERNOR -

VICTORIA WHITMORE
- EXECUTIVE DIRECTOR -

ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
1740 W. ADAMS STREET, STE. 4600, PHOENIX, ARIZONA 85007
PHONE (602) 364-1-PET (1738) • FAX (602) 364-1039
VETBOARD.AZ.GOV

INVESTIGATIVE COMMITTEE REPORT

TO: Arizona State Veterinary Medical Examining Board

FROM: AM Investigative Committee: Robert Kritsberg, DVM - Chair
Christina Tran, DVM
Carolyn Ratajack
Jarrod Butler, DVM
Steven Seiler

STAFF PRESENT: Tracy A. Riendeau, CVT - Investigations
Sabrina Kahn, Assistant Attorney General

RE: Case: 20-79
Complainant(s): Lisa and Gary Kravetz
Respondent(s): Megan Helgeson, D.V.M. (License: 7443)

SUMMARY:
Complaint Received at Board Office: 2/24/20
Committee Discussion: 8/4/20
Board IIR: 9/16/20

APPLICABLE STATUTES AND RULES:
Laws as Amended August 2018 (Lime Green); Rules as Revised September 2013 (Yellow).

On January 22, 2020, "Ernie," a 5-year-old male Yorkshire Terrier was transferred to Respondent for ongoing treatment of suspected pancreatitis. After examination and diagnostics, Respondent contacted Mrs. Kravetz with an update reporting that the dog was stable but anorexic. Due to the dog's six day history of poor appetite, Respondent recommended placing a nasogastric tube (NGT); Mrs. Kravetz approved.

Technical staff placed the NGT and performed radiographs to verify placement. Respondent's associate reviewed the radiographs and noted that the NGT was placed in the trachea, not the esophagus, therefore instructed staff to remove the NGT. Upon its removal, the dog went into respiratory distress. CPR was performed and Complainants were contacted. Resuscitation efforts were unsuccessful and Complainants requested the efforts to cease.

Complainants were noticed and appeared with attorney, Tricia Schafer, telephonically.
Respondent was noticed and appeared telephonically. Attorney David Stoll appeared.

The Committee reviewed medical records, testimony, and other documentation as described below:

- Complainant(s) narrative: *Gary and Lisa Kravetz*
- Respondent(s) narrative/medical record: *Megan Helgeson, DVM*
- Consulting Veterinarian(s) narrative/medical record: *Stacey Duffy, DVM – Raintree Pet Resort & Medical Center; Sundi Ashenfelter, DVM – VCA McCormick Ranch Animal Hospital.*

PROPOSED 'FINDINGS of FACT':

1. On January 16, 2020 (6:45pm), the dog was presented to Dr. Baker at VCA McCormick Ranch Animal Hospital and Emergency Center for shaking for about an hour. It was reported that the dog had a bad seizure the previous day and was seen by the regular veterinarian (no records submitted for that day, 1/15/20, from Raintree Pet Resort and Medical Center). The dog was on both keppra and phenobarbital for seizures. Complainants also relayed that the dog was not eating. Other concerns Complainants reported were concern for possible scorpion sting and possible ingestion of a calcium tablet.

2. Dr. Baker examined the dog; the dog was not actively seizing, abdomen palpated tense, and the dog was nervous, shaking and stiff during the exam. Dr. Baker explained to Complainants that the dog's behavior could be related to gastrointestinal upset since the abdomen was tense and stool soft. He recommended hospitalization for monitoring, blood work and radiographs. Complainants declined and elected to take the dog home.

3. Later that evening (8:58pm), Complainants re-presented the dog to Dr. Baker with concerns the dog could not get comfortable. The dog had received his seizure medication for the evening. Dr. Baker examined the dog and discussed his findings with Complainants – he concluded that the dog could be having intestinal upset due to possible unknown dietary indiscretion, foreign body, pancreatitis, hepatopathy, renal disease, inflammatory disease, etc. The dog could also be having musculoskeletal discomfort, or possibly an early neurological issue.

4. Dr. Baker recommended hospitalizing the dog for supportive care including pain medication, SQ fluids, and Pepcid. He also recommended blood work and radiographs. Complainants elected to hospitalize the dog for supportive care and declined diagnostics. The dog was admitted and administered SQ fluids, buprenorphine, and famotidine.

5. On January 17, 2020, the dog did well overnight, no seizures, and took medications with i/d diet. Complainants were to pick up the dog and had a recheck appointment with their regular DVM later that day.

6. Later that day, the dog was presented to Dr. Duffy at Raintree Pet Resort and Medical Center for a follow up exam from the emergency premises for abdominal pain and decreased appetite. Complainants reported that the dog ate French fries the day before. Dr. Duffy examined the dog and noted a tense abdomen and mild abdominal pain. Blood work was performed and revealed an abnormal cPL Snap test, Bands suspected, ALP 512, Amylase <2500, and lipase 5948. Radiographs revealed increased liver, gas filled stomach, increased opacity in the area of the pancreas.

7. Dr. Duffy discussed her findings with Complainants regarding her concern for pancreatitis; they agreed on a treatment plan including SQ fluids and GI protectants. The dog was administered and discharged with the following:

a. Cerenia SQ/Cerenia tablets;
b. Famotadine SQ/famotidine tablets;
c. Ondansetron SQ/ondansetron tablets;
d. Convenia SQ;
e. Hydromorphone SQ;
f. Fluids SQ; and
g. Hills i/d diet.

8. According to Dr. Duffy, she contacted Complainants daily for updates and was advised that the dog was doing much better at home. The dog was presented to Dr. Duffy daily for SQ fluid therapy.

9. On January 20, 2020, Complainants reported to Dr. Duffy that the dog suddenly became worse and was vomiting. Dr. Duffy recommended bringing the dog in for exam and repeat blood work; Complainants agreed. Repeat blood work revealed an abnormal cPL Snap test, ALP < 2000, ALT 133; and Mono 1.3. Dr. Duffy's differential diagnosis was pancreatitis with secondary liver insult. She advised Complainants that the dog was still healing from pancreatitis. The pancreas lives next to the liver therefore the liver values were elevated due to the pancreas being inflamed. Dr. Duffy dispensed Enrofloxacin and Entyce, as well as administering the dog SQ fluids.

10. On January 21, 2020, Dr. Duffy's medical records state the dog was hospitalized for part of the day for IV fluids and supportive care. Dr. Duffy stated that after monitoring the dog for approximately 5 hours, she was concerned about the dog's lack of response to the current treatment. She recommended Complainants have additional diagnostics, including an abdominal ultrasound, and potentially remain on IV fluid therapy overnight. Since Dr. Duffy's premises did not offer those services and do not have overnight staff, she recommended transferring to VETMED. Complainants agreed to transfer the dog to VETMED that afternoon.

11. Later that day, the dog was presented to Dr. Brigham at VETMED for further diagnostics. The dog was examined; Dr. Brigham discussed with Complainants about admitting the dog for supportive care for presumed pancreatitis and alter the plan if necessary after the abdominal ultrasound was performed. Complainants approved and the dog was hospitalized on IV fluids and medications for supportive care.

12. Later that day, Dr. Crooks performed an abdominal ultrasound on the dog which revealed pancreatitis with possible loss of blood flow to part of the pancreas; mild to moderate distension of the gallbladder with some inspissated bile.

13. The dog's care was transferred to Dr. Lautenschlager for overnight monitoring. The dog was quiet, alert and responsive; remained comfortable with normal vitals overnight. There was no vomiting or regurgitation noted and no interest in food.

14. The next morning (1/22/20), Respondent took over the care of the dog. The dog had a

weight = 5.3kg, a temperature = 99.3 degrees, a pulse rate = 130bpm and a respiration rate = 30bpm. The dog's abdomen palpated tense but non-painful and a focal recheck ultrasound was performed by Dr. Crooks. The pancreas was similar to the previous day. However, a newly identified moderate sized anechoic region – consistent with pancreatic cyst or sterile abscess – was noted dorsal/deep to the focal region.

15. The dog had a guarded to poor prognosis. The dog had no interest in food and given the history of the dog's persistent anorexia, Respondent recommended nasogastric tube (NGT) placement for initiation of enteral nutrition; Complainants approved.

16. At 12pm, technical staff member, Ms. Rebecca Kelly, placed a 6 French via the left nares and took a radiograph to confirm appropriate placement. Respondent's associate, Dr. Bailey, reviewed the radiographs and expressed concern with the NGT placement – Respondent confirmed that the NGT was in the trachea, not the esophagus, and the end of the NGT was within the retroperitoneal space. Dr. Bailey had already instructed Ms. Kelly to remove the NGT – Respondent walked into the radiology room as the dog's NGT was removed and he developed respiratory distress. The dog's mucous membranes appeared cyanotic and the dog developed an agonal breathing pattern. The dog was immediately moved to the STAT triage table and CPCR was initiated along with endotracheal tube placement and manual ventilation. A thoracic FAST was conducted and pneumothorax was identified; thoracocentesis was immediately performed and air was continuously aspirated confirming the presence of pneumothorax.

17. At this point, Respondent contacted Complainants and advised them that the dog arrested during NGT placement and CPR was being performed. She explained that the primary concern for the cause of the dog's arrest event was air leakage from the lungs due to trauma from the NGT leading the dog to stop breathing. Respondent recommended open chest CPCR on the dog if Complainants would like to continue resuscitation efforts – Complainants approved and headed to the premises.

18. Complainants visited the dog while CPR was being performed then Respondent spoke with them advising that the dog was not responding. Respondent again explained that she suspected the cause of the dog's arrest was likely due to the NGT being accidently placed into the trachea and not the esophagus, puncturing the dog's lung.

19. After some discussion, Complainants elected to discontinue CPR after being told that the likelihood of getting the dog back was minimal. Respondent apologized for the complication and relayed that NGT placement was performed numerous times per week at the premises. A necropsy was offered to be performed at an outside laboratory to confirm the suspected cause of the dog's arrest. Complainants declined and elected private cremation with ashes returned.

COMMITTEE DISCUSSION:

The Committee discussed that Respondent was ultimately responsible for what had occurred even though she was not the individual passing the NG tube.

COMMITTEE'S PROPOSED CONCLUSIONS of LAW:

The Committee concluded that possible violations of the *Veterinary Practice Act* occurred.

COMMITTEE'S RECOMMENDED DISPOSITION:

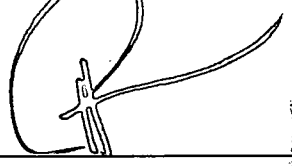
Motion: It was moved and seconded the Board find:

ARS § 32-2232 (11) Gross negligence; treatment of a patient or practice of veterinary medicine resulting in injury, unnecessary suffering or death that was caused by carelessness, negligence or the disregard of established principles or practices for the incorrect placement of the NG tube, which was directly related to the dog's death.

ARS § 32-2232 (22) Medical incompetence in the practice of veterinary medicine for directing the veterinary assistant to place the NG tube; the veterinary assistant incompetently inserted the NG tube.

Vote: The motion was approved with a vote of 5 to 0.

The information contained in this report was obtained from the case file, which includes the complaint, the respondent's response, any consulting veterinarian or witness input, and any other sources used to gather information for the investigation.



Tracy A. Riendeau, CVT
Investigative Division

DOUGLAS. A DUCEY
GOVERNOR

VICTORIA WHITMORE
EXECUTIVE DIRECTOR

ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD

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IN ACCORDANCE WITH § A.R.S. 32-2237(D): "IF THE BOARD REJECTS ANY RECOMMENDATION CONTAINED IN A REPORT OF THE INVESTIGATIVE COMMITTEE, IT SHALL DOCUMENT THE REASONS FOR ITS DECISION IN WRITING."

At the October 21, 2020 meeting of the Arizona State Veterinary Medical Examining Board, the Board conducted an Informal Interview in Case 20-79, In Re: Megan Helgeson, DVM.

The Board considered the Investigative Committee Findings of Fact, Conclusions of Law, and Recommended Disposition:

- *ARS § 32-2232 (11) Gross negligence; treatment of a patient or practice of veterinary medicine resulting in injury, unnecessary suffering or death that was caused by carelessness, negligence or the disregard of established principles or practices for the incorrect placement of the NG tube, which was directly related to the dog's death.*

- *ARS § 32-2232 (22) Medical incompetence in the practice of veterinary medicine for directing the veterinary assistant to place the NG tube; the veterinary assistant incompetently inserted the NG tube.*

Following the informal interview with Respondent, the Board concluded that it is acceptable, and common, for non-licensed/certified staff to place an NG tube as directed by a licensed veterinarian. Additionally, while placing an NG tube, it is not uncommon for the NG to enter into the trachea. The Board determined that this incident was a rare complication and was not a violation of the Veterinary Practice Act.

Respectfully submitted this 18TH day of November 2020.

Arizona State Veterinary Medical Examining Board

Jim Loughead, Chair